questions or concerns about this notice, contact [provide contact information for the health insurance issuer]. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.''

(e) *Applicability.* The provisions of this section apply for policy years beginning on or after July 1, 2012.

[77 FR 16468, Mar. 21, 2012, as amended at 78 FR 13439, Feb. 27, 2013; 79 FR 13834, Mar. 11, 2014]

§ 147.150 Coverage of essential health benefits.

(a) *Requirement to cover the essential health benefits package.* A health insurance issuer offering health insurance coverage in the individual or small group market must ensure that such coverage includes the essential health benefits package as defined in section 1302(a) of the Affordable Care Act effective for plan or policy years beginning on or after January 1, 2014.

(b) *Cost-sharing under group health plans.* [Reserved]

(c) *Child-only plans.* If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d)(1) of the Affordable Care Act, the issuer must offer coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

[78 FR 12865, Feb. 25, 2013]

§ 147.160 Parity in mental health and substance use disorder benefits.

(a) *In general.* The provisions of § 146.136 of this subchapter apply to health insurance coverage offered by health insurance issuer in the individual market in the same manner and to the same extent as such provisions apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the large group market.

(b) *Applicability date.* The provisions of this section apply for policy years beginning on or after the applicability dates set forth in § 146.136(i) of this subchapter. This section applies to non-grandfathered and grandfathered health plans as defined in § 147.140.

[78 FR 68296, Nov. 13, 2013]

§ 147.200 Summary of benefits and coverage and uniform glossary.

(a) *Summary of benefits and coverage–* (1) *In general.* A group health plan (and its administrator as defined in section 3(16)(A) of ERISA), and a health insurance issuer offering group or individual health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) *SBC provided by a group health insurance issuer to a group health plan—* (A) *Upon application.* A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

(B) *By first day of coverage (if there are changes).* If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage.

(C) *Upon renewal.* If the issuer renews or reissues the policy, certificate, or contract of insurance (for example, for a succeeding policy year), the issuer must provide a new SBC as follows:

(*1*) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must be provided no later than the date the written application materials are distributed.

(*2*) If renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the

SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(D) *Upon request.* If a group health plan (or its sponsor) requests an SBC or summary information about a health insurance product from a health insurance issuer offering group health insurance coverage, an SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

(ii) *SBC provided by a group health insurance issuer and a group health plan to participants and beneficiaries*—(A) *In general.* A group health plan (including its administrator, as defined under section 3(16) of ERISA), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary (as defined under sections 3(7) and 3(8) of ERISA), and consistent with paragraph (a)(1)(iii) of this section, with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.

(B) *Upon application.* The SBC must be provided as part of any written application materials that are distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date on which the participant is eligible to enroll in coverage for the participant or any beneficiaries.

(C) *By first day of coverage (if there are changes).* If there is any change to the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

(D) *Special enrollees.* The plan or issuer must provide the SBC to special enrollees (as described in 45 CFR 146.117) no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment.

(E) *Upon renewal.* If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), the plan or issuer must provide a new SBC when the coverage is renewed, as follows:

(*1*) If written application is required for renewal (in either paper or electronic form), the SBC must be provided no later than the date on which the written application materials are distributed.

(*2*) If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(F) *Upon request.* A plan or issuer must provide the SBC to participants or beneficiaries upon request for an SBC or summary information about the health coverage, as soon as practicable, but in no event later than seven business days following receipt of the request.

(iii) *Special rules to prevent unnecessary duplication with respect to group health coverage*—(A) An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the other rules of this section. Therefore, for example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual.

(B) If a single SBC is provided to a participant and any beneficiaries at the participant's last known address then the requirement to provide the

SBC to the participant and any beneficiaries is generally satisfied. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

(C) With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically upon renewal only with respect to the benefit package in which a participant or beneficiary is enrolled; SBCs are not required to be provided automatically upon renewal with respect to benefit packages in which the participant or beneficiary is not enrolled. However, if a participant or beneficiary requests an SBC with respect to another benefit package (or more than one other benefit package) for which the participant or beneficiary is eligible, the SBC (or SBCs, in the case of a request for SBCs relating to more than one benefit package) must be provided upon request as soon as practicable, but in no event later than seven business days following receipt of the request.

(iv) *SBC provided by a health insurance issuer offering individual health insurance coverage*—(A) *Upon application.* A health insurance issuer offering individual health insurance coverage must provide an SBC to an individual covered under the policy (including every dependent) upon receiving an application for any health insurance policy, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

(B) *By first day of coverage (if there are changes).* If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the issuer must update and provide a current SBC to the individual no later than the first day of coverage.

(C) *Upon renewal.* The issuer must provide the SBC to policyholders annually at renewal. The SBC must reflect any modified policy terms that would be effective on the first day of the new policy year. The SBC must be provided as follows:

(*1*) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must be provided no later than the date on which the written application materials are distributed.

(*2*) If renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new policy year; however, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(D) *Upon request.* A health insurance issuer offering individual health insurance coverage must provide an SBC to any individual or dependent anytime an individual requests an SBC or summary information about a health insurance product as soon as practicable, but in no event later than seven business days following receipt of the request. For purposes of this paragraph (a)(1)(iv)(D), a request for an SBC or summary information about a health insurance product includes a request made both before and after an individual submits an application for coverage.

(v) *Special rule to prevent unnecessary duplication with respect to individual health insurance coverage.* If a single SBC is provided to an individual and any dependents at the individual's last known address, then the requirement to provide the SBC to the individual and any dependents is generally satisfied. However, if a dependent's last known address is different than the individual's last known address, a separate SBC is required to be provided to the dependent at the dependents' last known address.

(2) *Content*—(i) *In general.* Subject to paragraph (a)(2)(iii) of this section, the SBC must include the following:

(A) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage, in accordance with guidance as specified by the Secretary;

(B) A description of the coverage, including cost sharing, for each category of benefits identified by the Secretary in guidance;

(C) The exceptions, reductions, and limitations of the coverage;

(D) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;

(E) The renewability and continuation of coverage provisions;

(F) Coverage examples, in accordance with paragraph (a)(2)(ii) of this section;

(G) With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) of the Internal Revenue Code and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;

(H) A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

(I) Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance);

(J) For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

(K) For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and

(L) An Internet address for obtaining the uniform glossary, as described in paragraph (c) of this section, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(ii) *Coverage examples.* The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions) in accordance with this paragraph (a)(2)(ii).

(A) *Number of examples.* The Secretary may identify up to six coverage examples that may be required in an SBC.

(B) *Benefits scenarios.* For purposes of this paragraph (a)(2)(ii), a benefits scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality. The Secretary will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

(C) *Illustration of benefit provided.* For purposes of this paragraph (a)(2)(ii), to illustrate benefits provided under the plan or coverage for a particular benefits scenario, a plan or issuer simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the plan, policy, or benefit package. The illustration of benefits provided will take into account any cost sharing, excluded benefits, and other limitations on coverage, as specified by the Secretary in guidance.

(iii) *Coverage provided outside the United States.* In lieu of summarizing coverage for items and services provided outside the United States, a plan or issuer may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. In any case, the plan or issuer must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the plan or coverage within the United States.

(3) *Appearance.* A group health plan and a health insurance issuer must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance. The SBC must be presented in a uniform format,

use terminology understandable by the average plan enrollee (or, in the case of individual market coverage, the average individual covered under a health insurance policy), not exceed four double-sided pages in length, and not include print smaller than 12-point font. A health insurance issuer offering individual health insurance coverage must provide the SBC as a stand-alone document.

(4) *Form*—(i) An SBC provided by an issuer offering group health insurance coverage to a plan (or its sponsor), may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the following three conditions are satisfied—

(A) The format is readily accessible by the plan (or its sponsor);

(B) The SBC is provided in paper form free of charge upon request; and

(C) If the electronic form is an Internet posting, the issuer timely advises the plan (or its sponsor) in paper form or email that the documents are available on the Internet and provides the Internet address.

(ii) An SBC provided by a group health plan or health insurance issuer to a participant or beneficiary may be provided in paper form. Alternatively, for non-Federal governmental plans, the SBC may be provided electronically if the plan conforms to either the substance of the ERISA provisions at 29 CFR 2590.715–2715(a)(4)(ii), or the provisions governing electronic disclosure for individual health insurance issuers set forth in paragraph (a)(4)(iii) of this section.

(iii) An issuer offering individual health insurance coverage must provide an SBC in a manner that can reasonably be expected to provide actual notice in paper or electronic form.

(A) An issuer satisfies the requirements of this paragraph (a)(4)(iii) if the issuer:

(*1*) Hand-delivers a printed copy of the SBC to the individual or dependent;

(*2*) Mails a printed copy of the SBC to the mailing address provided to the issuer by the individual or dependent;

(*3*) Provides the SBC by email after obtaining the individual's or dependent's agreement to receive the SBC or other electronic disclosures by email;

(*4*) Posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with paragraphs (a)(4)(iii)(A)(*1*) through (*3*), that the SBC is available on the Internet and includes the applicable Internet address; or

(*5*) Provides the SBC by any other method that can reasonably be expected to provide actual notice.

(B) An SBC may not be provided electronically unless:

(*1*) The format is readily accessible;

(*2*) The SBC is placed in a location that is prominent and readily accessible;

(*3*) The SBC is provided in an electronic form which can be electronically retained and printed;

(*4*) The SBC is consistent with the appearance, content, and language requirements of this section;

(*5*) The issuer notifies the individual or dependent that the SBC is available in paper form without charge upon request and provides it upon request.

(C) *Deemed compliance.* A health insurance issuer offering individual health insurance coverage that provides the content required under paragraph (a)(2) of this section, as specified in guidance published by the Secretary, to the federal health reform Web portal described in 45 CFR 159.120 will be deemed to satisfy the requirements of paragraph (a)(1)(iv)(D) of this section with respect to a request for summary information about a health insurance product made prior to an application for coverage. However, nothing in this paragraph should be construed as otherwise limiting such issuer's obligations under this section.

(5) *Language.* A group health plan or health insurance issuer must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this paragraph (a)(5), a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of §147.136(e) of this chapter are met as applied to the SBC.

(b) *Notice of modification.* If a group health plan, or health insurance issuer offering group or individual health insurance coverage, makes any material modification (as defined under section

102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees (or, in the case of individual market coverage, an individual covered under a health insurance policy) not later than 60 days prior to the date on which the modification will become effective. The notice of modification must be provided in a form that is consistent with paragraph (a)(4) of this section.

(c) *Uniform glossary*—(1) *In general.* A group health plan, and a health insurance issuer offering group health insurance coverage, must make available to participants and beneficiaries, and a health insurance issuer offering individual health insurance coverage must make available to applicants, policyholders, and covered dependents, the uniform glossary described in paragraph (c)(2) of this section in accordance with the appearance and form and manner requirements of paragraphs (c)(3) and (4) of this section.

(2) *Health-coverage-related terms and medical terms.* The uniform glossary must provide uniform definitions, specified by the Secretary in guidance, of the following health-coverage-related terms and medical terms:

(i) Allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

(ii) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits), as specified in guidance.

(3) *Appearance.* A group health plan, and a health insurance issuer, must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee (or, in the case of individual market coverage, an average individual covered under a health insurance policy).

(4) *Form and manner.* A plan or issuer must make the uniform glossary described in this paragraph (c) available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request.

(d) *Preemption.* For purposes of this section, the provisions of section 2724 of the PHS Act continue to apply with respect to preemption of State law. In addition, State laws that require a health insurance issuer to provide an SBC that supplies less information than required under paragraph (a) of this section are preempted.

(e) *Failure to provide.* A health insurance issuer or a non-federal governmental health plan that willfully fails to provide information required under this section is subject to a fine of not more than $1,000 for each such failure. A failure with respect to each covered individual constitutes a separate offense for purposes of this paragraph (e). HHS will enforce these provisions in a manner consistent with 45 CFR 150.101 through 150.465.

(f) *Applicability date*—(1) This section is applicable to group health plans and group health insurance issuers in accordance with this paragraph (f). (*See* §147.140(d), providing that this section applies to grandfathered health plans.)

(i) For disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including re-enrollees and late enrollees), this section applies

beginning on the first day of the first open enrollment period that begins on or after September 23, 2012; and

(ii) For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), this section applies beginning on the first day of the first plan year that begins on or after September 23, 2012.

(2) For disclosures with respect to plans, and to individuals and dependents in the individual market, this section is applicable to health insurance issuers beginning September 23, 2012.

[77 FR 8702, Feb. 14, 2012]

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

Subpart A—General Provisions

Subpart B—Requirements Relating to Access and Renewability of Coverage

Subpart C—Requirements Related to Benefits

Subpart D—Preemption; Excepted Benefits

Subpart E—Grants to States for Operation of Qualified High Risk Pools

AUTHORITY: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

SOURCE: 62 FR 16995, Apr. 8, 1997, unless otherwise noted.

Subpart A—General Provisions

§ 148.101 Basis and purpose.

This part implements sections 2741 through 2763 and 2791 and 2792 of the PHS Act. Its purpose is to guarantee the renewability of all coverage in the individual market. It also provides certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth and protects all individuals and family members who have, or seek, individual health insurance coverage from discrimination based on genetic information.

[79 FR 30340, May 27, 2014]

§ 148.102 Scope, applicability, and effective dates.

(a) *Scope and applicability.* (1) Individual health insurance coverage includes all health insurance coverage (as defined in §144.103 of this subchapter) that is neither health insurance coverage sold in connection with an employment-related group health plan, nor short-term, limited-duration coverage as defined in §144.103 of this subchapter.

(2) The requirements that pertain to guaranteed renewability for all individuals, to protections for mothers and newborns with respect to hospital stays in connection with childbirth, and to protections against discrimination based on genetic information apply to all issuers of individual health insurance coverage in the State.

(b) *Applicability date.* Except as provided in §148.124 (certificate of creditable coverage), §148.170 (standards relating to benefits for mothers and newborns), and §148.180 (prohibition of health discrimination based on genetic